

CHRISTIAN LIFE ACADEMY

YEARLY EMERGENCY MEDICAL CONSENT FORM

School Year _____ Grade _____ Teacher _____

Student Name _____ Birthdate _____

Address _____ Last _____ First _____ Phone _____

Street _____ City _____

Guardian/
Father/Name _____

Place of Employment _____ Phone Number _____

Guardian/
Mother/Name _____

Place of Employment _____ Phone Number _____

Emergency Contacts if parent/guardian cannot be reached:

Name _____ Phone No. _____

Name _____ Phone No. _____

Does your child have any medical condition or allergies which may require medical treatment or to which a physician should be alerted? No _____ Yes _____ If yes, please explain _____

Related medications (name, dosage, frequency) _____

Emergency Consent:

In the event that I cannot be contacted, I hereby give my consent for:

- 1.) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or if they are unavailable, by another licensed practitioner.
- 2.) the transfer of my child to _____ (preferred hospital) or any hospital reasonably accessible. (This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the procedure.
- 3.) emergency transportation in a privately owned car or commercial vehicle at my expense.

Parent/Guardian Signature _____ Date _____

Refusal to Emergency Consent:

I do **not** give my consent for emergency medical treatment of my child. I wish the school to take **no** action or to _____

Parent/Guardian Signature _____ Date _____